DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 11/24/12

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445393	A. BUILDING _____ B. WING _____	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT MONTEAGLE (THE)	26 SECOND STREET MONTEAGLE, TN 37356

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F 000	INITIAL COMMENTS A Recertification survey and complaint investigation #30463 were completed on on October 8-10, 2012. No deficiencies were cited related to complaint investigation #30463 under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000	**Disclaimer:** The Bridge at Monteagle does not believe and does not admit that any deficiencies existed either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to investigate an allegation of abuse for one resident (#147) of thirty-nine residents reviewed. The findings included: Resident #147 was admitted on June 28, 2012 to the facility with diagnoses of Dementia, Obesity, and Diabetes. Medical record review of the admission Minimum Data Set (MDS) dated July 3, 2012, revealed the resident was moderately cognitively impaired. Medical record review of a Social Service Progress Note dated September 24, 2012, revealed "...resident had expressed...another resident had made some sexual comments..."	F 226		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	ADMINISTRATOR	12/27/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 226	Continued From page 1 Medical record review of a Social Service Review dated October 3, 2012, revealed "...BIMS (Brief Interview of Mental Status) is 15..." Review of facility policy, Abuse, Neglect, and Misappropriation, effective January 2012 revealed "...it is the intent of this facility to immediately report and thoroughly investigate allegations of abuse...facility staff will be educated to report any oral or written reports of allegations of abuse...accident and incident reports will be completed by facility...a thorough investigation will be initiated immediately for all alleged incidents involving residents..." Interview with Resident #147 on October 9, 2012, at 8:55 a.m., in the resident's room, revealed the resident had reported to a staff member that another resident had "borderline sexually harassed" the resident verbally. Interview with the Director of Social Service on October 10, 2012, at 1:00 p.m., in the social service office, confirmed an allegation of abuse had been made by the resident two weeks ago. Continued interview at this time confirmed the Director of Social Service informed the former Administrator of the allegation of abuse and no investigation had been completed. Interview with the current Administrator on October 10, 2012, at 1:30 p.m., in the Marketing office, confirmed the facility had failed to investigate an allegation of abuse for one resident.	F 226	**F226 Develop/Implement Abuse/Neglect, Etc Policies** 11/6/12 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. **Residents affected:** Resident #147 was assessed for emotional and psychological stress related to being sexually harassed by another resident by social services and psych services. An abuse investigation was initiated by the administrator with abuse training for staff with written competency by the DON on 10/10/12. **Residents potentially affected:** All Residents have the potential to be affected by the cited practice. All residents with a BIMS of 13 or more were interviewed by social services director/social services assistant 10/12/12 to ensure no sexual harassment concerns were identified. None were verbalized or expressed. **Systemic measures:** The DON/designee will educate social services director/ social services assistant and administrator on abuse policy and investigative procedure by 10/19/12. The Social service director/designee will report an allegation of sexual harassment to the administrator and the clinical team throughout the week in stand-up daily. Any residents with sexual harassment concerns will be placed on the whiteboard process and assessed for emotional/psycho social wellbeing. The administrator/designee will follow-up the next working day to review investigation process. The DON/designee will educate staff on abuse with written competency. **Monitoring measures:** The social services director/designee will report any sexual harassment concerns throughout the work week to the administrator/designee. Concerns will be addressed in monthly QA X 2 months and upon occurrence thereafter.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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F 241	Continued From page 2 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to maintain dignity for two residents (#71, #95) of thirty-nine residents reviewed. The findings included: Resident #71 was admitted to the facility on November 21, 2011, with diagnoses including Dysphagia Weight Loss, Traumatic Brain Injury, and Anxiety. Medical record review of the Care Plan dated August 1, 2012, revealed the resident required assistance with all Activities of Daily Living (ADL)'s. Observation on October 8, 2012, at 10:00 a.m., in the dining room, revealed the resident sitting in a wheel chair at the doorway with a pink substance dripping from the mouth and on the clothes. Observation on October 8, 2012, at 12:20 p.m., in the dining room, revealed resident #71 sitting at the table with a pink substance dripping from the mouth and on the clothes. Observation on October 8, 2012, at 12:25 p.m., in the dining room, revealed resident #71 had been	F 241	**F241 Dignity and Respect of Individuality** 11/16/12 **The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.** **Residents Affected:** Resident #71 and #95 were assessed by social services director/social service assistant for emotion and psychosocial concerns. None were identified. The DON was educated by the Clinical consultant and CNA #4 was educated by the DON related to dignity 10/8/12 **Residents potentially affected:** All residents have the potential to be affected by this cited practice related to dignity. The DON/designee will educate direct care staff on dignity. **Systemic Measures:** The DON/designee will educate all direct care staff on dignity during dining. Department heads will be assigned to the dining room during afternoon meal service through-out the work week and report any dignity issues immediately to the social service director/designee. The identified dignity concerns will be reported in stand up to the DON for follow-up education. The DON/designee will coach and mentor staff identified x2 weeks and provided a written competency related to dignity. **Monitoring Changes:** The DON/designee will report any coaching and mentoring of staff to the administrator/designee. Areas of concerns will be addressed in monthly QA X 2 months and upon occurrence thereafter.	

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F 241	Continued From page 3 served lunch, and the silverware was still wrapped in the napkin. Further observation at this time revealed the resident eating mashed potatoes and meatloaf with the hands. Observation on October 8, 2012, at 12:30 p.m., revealed Certified Nurse Aide (CNA) #4 spoke to the resident and failed to unwrap the silverware and the resident continued to eat with the hands. Observation on October 8, 2012, at 12:40 p.m., in the dining room, revealed a housekeeper unwraped the resident's silverware and the resident completed the meal using the silverware. Interview with the Director of Nursing (DON) on October 8, 2012, at 2:00 p.m., in the DON office, confirmed the resident's dignity was not maintained when the resident was not offered care to clean the face or provided silverware timely and had to eat with the hands. Resident #95 was admitted to the facility on July 2, 2011, and readmitted on January 18, 2012, with diagnoses including Anemia, Hypertension, and Chronic Obstructive Pulmonary Disease. Medical record review of the Care Plan dated August 8, 2012, the resident had cognitive impairment, required assistance with all Activities of Daily Living, and was incontinent of urine. Observation on October 8, 2012, at 12:45 p.m., revealed the resident sitting in the dining room in a wheelchair. Further observation at this time revealed a puddle of liquid in the floor under the resident's wheelchair.	F 241		

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F 241	Continued From page 4 Observation on October 8, 2012, at 12:50 p.m., revealed the DON entered the dining room and placed paper towels under the resident's wheelchair in the puddle of liquid. Further observation at this time revealed the DON exited the dining room, re-entered the dining room and removed the paper towels from under the resident's chair. Observation on October 8, 2012, at 1:27 p.m., in the dining room, revealed the resident continued to sit in the dining room, no incontinence care had been provided, and the resident's pants were wet. Interview with the DON on October 10, 2012, at 2:00 p.m., in the DON's office, confirmed the resident's dignity was not maintained when the resident was not provided incontinence care.	F 241	**F272 Comprehensive Assessments** The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. **Resident Affected:** Resident #11,#18,#23 MDS was modified to reflect their current condition and functional status. The DON educated the MDS coordinator/patient care coordinator and dietary manager regarding accurate comprehensive assessments on 10/19/12. **Residents potentially affected:** All residents have the potential to be affected by this cited practice regarding Comprehensive MDS assessments. Residents that required a MDS assessment in the past 30 days will be reviewed for accuracy coding by the DON/designee. **System measures:** The DON/designee educated MDS coordinator, patient care coordinator and dietary manager on accuracy of MDS data and assessments. The MDS coordinator and Patient care coordinator will review the past 30 days of quarterly, annual and significant change assessments that were completed. The DON/administrative nurse will review 100% of quarterly, annual and significant change assessments for 1 month then 50% the following month for accuracy of data. Concerns identified by the DON/ Administrator nurse related to MDS coding accuracy will be addressed throughout the work week in clinical meeting and corrected immediately. **Monitoring changes:** The MDS coordinator/patient care coordinator will provide a weekly validation report to the administrator to review for accuracy. The DON/Administrative nurse will report discrepancies identified in MDS coding to the administrator. The administrator will report MDS coding discrepancies to the monthly QA x 2 months and upon occurrence thereafter.	11/16/12
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272		

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F 272	Continued From page 5 Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to conduct a comprehensive assessment on three residents (#11, #18, and #23) of thirty-nine residents reviewed. The findings included: Resident #11 was admitted to the facility on September 9, 2010, with diagnoses including Closed Intracapsular Fracture, Pneumonia, Muscle Weakness and Lumbar Fracture. Medical review of the readmission Minimum Data Set (MDS), dated September 21, 2012, revealed the resident scored a 15 on the Brief Interview for	F 272		

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F 272	Continued From page 6 Mental Status indicating the resident was cognitively intact. Further review revealed no documentation of the resident having dentures or having any mouth or facial pain, discomfort or difficulty with chewing. Medical record review of a Nurse's Note, dated August 28, 2012, revealed "...Slow to take medications...dentures ill-fitting..." Medical record review of a Nurses Note, dated September 21, 2012, revealed "...during med pass unable to take meds until dentures removed...states I have lost weight and can't even keep my dentures in...also related that meds have been getting hung on top of dentures...swallowed without difficulty after dentures removed..." Medical record review of a Nurse's Note, dated September 25, 2012, revealed "...Dentures are ill-fitting related to weight loss..." Observation on October 10. 2012, at 1:25 p.m., in the resident's room, revealed the resident sitting up on the bedside eating lunch. Continued observation revealed the dentures protruding from the resident's mouth and the resident stated "...it is hard to chew with these dentures because they are so loose..." Interview with Licensed Practical Nurse (LPN) #2 on October 10, 2012 at 1:35 p.m., in the West Wing Nurse's Station, revealed the "...residents dentures are very loose since...lost weight...they flop down when...eats and we have to take the dentures out so...can swallow (resident) medications because they get in the way..."	F 272		

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F 272	Continued From page 7 Interview with the Director of Nurses (DON) on October 10, 2012, at 2:00 p.m., in the conference room, confirmed the MDS assessment was inaccurate regarding the resident's dentures and failed to address the difficulty in chewing. Resident #18 was admitted to the facility on December 22, 2011, and readmitted on July 27, 2012, with diagnoses including Cerebral Vascular Accident, Dementia, and Diabetes Mellitus Type II. Medical record review of the quarterly MDS dated September 25, 2012, revealed the resident was currently on a scheduled toileting program. Interview with Certified Nurse Aide (CNA) #1 on October 10, 2012, at 10:10 a.m., confirmed the resident wears a brief, incontinent of urine 2-3 times a days, continent of bowel, searches for the bathroom, and not currently on a scheduled toileting program. Interview with Licensed Practical Nurse (LPN) #2 on October 10, 2012, at 10:20 a.m., in the West Wing Nurse's Station, confirmed the resident is continent at times, searched for the bathroom, and was not aware of a scheduled toileting program. Interview with the Restorative Nurse on October 10, 2012, at 10:40 a.m., in the rehabilitation office, confirmed the facility did not currently have any residents on a toileting program. Interview with the MDS Coordinator on October 10, 2012, at 11:00 a.m., in the conference room,	F 272		

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F 272	Continued From page 8 confirmed no bowel and bladder assessment for September 2012, had been completed, no individualized bladder training program had been established for the resident, and the quarterly MDS was not accurate. Resident #23 was admitted on March 8, 2007, with diagnoses including Senile Dementia, Alzheimer's Disease, Dysphasia, and Failure to Thrive. Medical record review of an annual MDS dated July 13, 2012, revealed the resident was currently on a therapeutic diet, no weight loss, no swallowing problems, and the current weight was seventy-eight pounds. Medical record review of the current Care Plan dated July 25, 2012, revealed "...resident is at nutrition risk...significant weight change...chewing problems...Failure to thrive...refuses to eat...mech (mechanical soft)...thickened liquids...Dx (diagnosis) of Dysphasia..." Medical record review of an Interdisciplinary Progress Note dated July 5, 2012, revealed "...current wt (weight) 66 lbs (pounds)...previous wt 68.5 lbs...nectar thick liquids..." Observation on October 9, 2012, at 7:00 p.m., in the west wing dining room, revealed the resident sitting in a wheelchair eating supper. Continued observation revealed the resident consumed 25% of the evening meal and refused to eat. Interview with the MDS coordinator and the Dietary Manager on October 9, 2012, at 9:34 a.m., confirmed the facility had failed to complete	F 272		

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F 272 F 279 SS=D	Continued From page 9 a Comprehensive MDS Assessment. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to complete an accurate comprehensive assessment and individualized care plan to include accurate dental status for one resident (#36) of three residents reviewed for dental services. The findings included: Resident (#36) was originally admitted to the	F 272 F 279	**F279 Develop Comprehensive Care plans** The facility must develop a comprehensive care plan for each resident that includes measureable objectives and timetables to meet a resident's medical, nursing, and mental and psychological needs that are identified in the comprehensive assessment. **Resident Affected:** Resident #36 care plan was updated to reflect current dental status and the potential for denture problems. The Resident was seen by the dentist on 10/12/12. The lower dentures are in the process of being repaired by one care dental solutions. Diet changed per resident request and MD order until lower dentures replaced. **Residents potentially affected:** All residents have the potential to be affected by this cited practice regarding dental issues not addressed on the care plan. Care plans of residents that currently wear dentures were reviewed to ensure interventions for potential problems were included in the plan of care. **System measures:** The DON/designee will educate MDS coordinator and patient care coordinator on accuracy of care plans related to dentures. The MDS coordinator/designee will review 100% of residents that currently have dentures to ensure dental issues or the potential for problems is care planned. The MDS coordinator/patient care coordinator will notify the DON/Social service director when denture concerns are identified during clinical meeting throughout the week. The MDS coordinator/patient care coordinator will update the care plan immediately to reflect their current plan of care related to dentures. **Monitoring changes:** The DON/Social service director will report to the administrator denture problems and/or issues identified. Any denture problems will be addressed monthly in QA x 2 months and upon occurrence thereafter.	11/6/12

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F 279	Continued From page 10 facility February 8, 2006, with diagnoses including Congestive Heart Failure, Hypertension, Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease. Medical record review of the annual Minimum Data Sets (MDS) dated June 18, 2012, revealed the resident was cognitively intact and the Oral/Dental assessment section had been coded "none of the above" in reference to the presence of natural teeth, mouth or facial pain or difficulty with chewing." Medical record review of the Nutritional Assessments dated February 9, 2011 and February 8, 2012, revealed the resident had no teeth and wore dentures. Medical record review of the Nutrition portion of the Interdisciplinary Care Plan, revealed the potential for denture problems was not addressed, no identification of dentures as a potential problem for the resident, no assessment of mouth problems for the resident, or planned dental interventions for the resident. Interview with the resident on October 8, 2012, in the East dining room confirmed the resident had no natural teeth, had worn dentures "for a long time" and "had several sets" but my lower denture broke and I haven't seen the dentist to get it fixed." The resident further stated he had told the facility about the broken denture and requested an appointment with the dentist. Interview with the Director of Nursing on October 10, 2012, at 10:30, at the East Nurse's Station, confirmed the facility was not aware of the	F 279		

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F 279	Continued From page 11 resident's broken denture, resident's Care Plan did not individually address dental/denture issues for the resident, and the resident's dental status and interventions should have been included in the plan of care.	F 279	**F280 Right to Participate Planning Care-Revise CP** **Resident Affected:** Resident #11 care plan was updated to reflect current dental status and the potential for denture problems. The Resident was seen by Dr. Shelton, DDS on 10/16/12 and 10/22/12. Resident #11's dentures are in the process of being replaced. Diet changed per resident request and MD order until dentures replaced. **Residents potentially affected:** All residents have the potential to be affected by this cited practice regarding dental issues not addressed on the care plan. Care plans of residents that currently wear dentures were reviewed to ensure interventions for potential problems were included in the plan of care. **System measures:** The DON/designee will educate MDS coordinator and patient care coordinator on accuracy of care plans related to dentures. The MDS coordinator/designee will review 100% of residents that currently have dentures to ensure dental issues or the potential for problems is care planned. The MDS coordinator/patient care coordinator will notify the DON/Social service director when denture concerns are identified during clinical meeting throughout the week. The MDS coordinator/patient care coordinator will update the care plan immediately to reflect their current plan of care related to dentures. **Monitoring changes:** The DON/Social service director will report to the administrator denture problems and/or issues identified. Any denture problems will be addressed monthly in QA x 2 months and upon occurrence thereafter.	11/16/12
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to revise a care plan related to ill fitting dentures for one resident (#11) of three resident's reviewed. The findings included:	F 280		

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F 280	Continued From page 12 Resident #11 was admitted to the facility on September 9, 2010 with diagnoses including Closed Intracapsular Fracture, Pneumonia, Muscle Weakness and Lumbar Fracture. Medical record review of the readmission Minimum Data Set (MDS), dated September 21, 2012, revealed the resident scored a 15 on the Brief Interview for Mental Status indicating the resident was cognitively intact. Further review revealed no documentation of the resident having dentures or having any mouth or facial pain, discomfort or difficulty with chewing. Medical record review of a Nurse's Note, dated August 28, 2012, revealed "...Slow to take medications...dentures ill-fitting..." Medical record review of a Nurses Note, dated September 21, 2012, revealed "...during med pass unable to take meds until dentures removed...states I have lost weight and can't even keep my dentures in...also related that meds have been getting hung on top of dentures ...swallowed without difficulty after dentures removed..." Medical record review of a Nurse's Note, dated September 25, 2012, revealed "...Dentures are ill-fitting related to weight loss..." Medical record review of the Nutrition Interdisciplinary Care Plan, last updated on October 4, 2012, revealed "...resident is at risk as evidenced by significant weight changes within the last 180 days...chewing problem ..." Continued review of the care plan revealed the	F 280		

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F 280	Continued From page 13 "ill-fitting dentures" were not addressed in the care plan. Observation on October 10, 2012, at 1:25 p.m., in the resident's room, revealed the resident sitting up on the bedside eating lunch. Continued observation revealed the dentures protruding from the resident's mouth and the resident stated "...it is hard to chew with these dentures because they are so loose..." Interview with Licensed Practical Nurse (LPN) #2 on October 10, 2012, at 1:35 p.m., in the West Wing Nurse's Station, revealed the "...residents dentures are very loose since (resident) has lost weight...they flop down when...eats and we have to take the dentures out so...can swallow...medications because they get in the way..." Interview with the Director of Nurses (DON) on October 10, 2012, at 2:00 p.m., in the conference room, confirmed the care plan had not been revised related to the resident's ill-fitting dentures.	F 280	**F281 Services Provided Meet Professional Standards** The services provided or arranged by the facility must meet professional standards of quality **Resident Affected:** Resident #129 vital signs were assessed by the licensed nurse. Vital signs were within normal limits. The Nurse Practitioner was notified and order for Nitroglycerin was clarified by the unit manager. **Residents potentially affected:** All residents that receive nitroglycerin patches have the potential to be affected by this cited practice. All resident's medication administration record whom had nitroglycerin patch orders were reviewed for accuracy of order to include dosage and removal of patch by the medical records director. **Systemic measures:** The DON/designee will educate licensed nurses on the administration of Nitroglycerin patches to include dose and administration and removal. The DON/unit managers will read orders out loud in the clinical meeting during the work week to check for appropriate dosage and timing of medication administration. The DON/designee will perform rounds on residents that receive Nitroglycerin patches weekly x 8 weeks. Any Nitroglycerin patches with discrepancies will be addressed and corrected immediately. **Monitoring changes** The DON/designee will report to the QA committee concerns identified with Nitroglycerin patches monthly X 2 months and upon occurrence thereafter.	11/16/12
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide timely removal of a resident's nitroglycerin patch per physician order, pharmacy instruction, and manufacturer's specifications for one resident	F 281		

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F 281	Continued From page 14 (#129) of thirteen residents reviewed for medication administration. The findings included: Medical record review of the resident's prescription label on the resident's box of nitroglycerin patches in the medication cart revealed "...Nitroglycerin 0.4mg/hr (milligrams per hour) patch apply 1 patch topically daily (ON 8AM, OFF 8PM)..." Medical record review of the Physician's Orders dated October 1-31, 2012, revealed "...Nitroglycerin patch Transdermal apply 1 patch daily..." Review of the manufacturer's specifications revealed "...an appropriate dosing schedule for nitroglycerin patches would include daily patch-on period of 10-12 hours and a daily patch-off period of 10-12 hours..." Observation of a random medication pass on October 9, 2012, at 8:00 a.m., in the resident's (#129) room revealed Licensed Practical Nurse #1 (LPN) removed the prior day's nitroglycerin patch before applying the resident's new patch. Interview with LPN #1 on October 9, 2012, at 8:45 a.m., in the East Hallway, confirmed the patch was not removed timely per Physician's Order, pharmacy label, and manufacturer's specifications.	F 281	**F282 Services by Qualified Persons/Per Care Plan** 11/16/12 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. **Resident Affected:** Resident #11 care plan was updated to reflect current dental status and the potential for denture problems. The Resident was seen by Dr. Shelton, DDS on 10/16/12 and 10/22/12. Resident #11's dentures are in the process of being replaced. Diet changed per resident request and MD order until dentures replaced. **Residents potentially affected:** All residents have the potential to be affected by this cited practice regarding dental issues not addressed on the care plan. Care plans of residents that currently wear dentures were reviewed to ensure interventions for potential problems were included in the plan of care. **System measures:** The DON/designee will educate MDS coordinator and patient care coordinator on accuracy of care plans related to dentures. The MDS coordinator/designee will review 100% of residents that currently have dentures to ensure dental issues or the potential for problems is care planned. The MDS coordinator/patient care coordinator will notify the DON/Social service director when denture concerns are identified during clinical meeting throughout the week. The MDS coordinator/patient care coordinator will update the care plan immediately to reflect their current plan of care related to dentures. **Monitoring changes:** The DON/Social service director will report to the administrator denture problems and/or issues identified. Any denture problems will be addressed monthly in QA x 2 months and upon occurrence thereafter.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		

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F 282	Continued From page 15 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide dental services for one resident (#11) for three resident's reviewed. The findings included: Resident #11 was admitted to the facility on September 9, 2010 with diagnoses including Closed Intracapsular Fracture, Pneumonia, Muscle Weakness and Lumbar Fracture. Medical review of the readmission Minimum Data Set (MDS), dated September 21, 2012, revealed the resident scored a 15 on the Brief Interview for Mental Status indicating the resident was cognitively intact. Further review revealed no documentation of the resident having dentures or having any mouth or facial pain, discomfort or difficulty with chewing. Medical record review of a Nurse's Note, dated August 28, 2012, revealed "...Slow to take medications...dentures ill-fitting..." Medical record review of a Nurses Note, dated September 21, 2012, revealed "...during med pass unable to take meds until dentures removed...states I have lost weight and can't even keep my dentures in...also related that meds have been getting hung on top of	F 282		

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F 282	Continued From page 16 dentures...swallowed without difficulty after dentures removed..." Medical record review of a Nurse's Note, dated September 25, 2012, revealed "...Dentures are ill-fitting related to weight loss..." Medical record review of the Nutrition Interdisciplinary Care Plan, last updated on October 4, 2012, revealed "...resident is at risk as evidenced by significant weight changes within the last 180 days...chewing problem..." Continued review of the care plan revealed the "ill-fitting dentures" were not addressed in the Care Plan. Observation on October 10, 2012 at 1:35 p.m., in the resident's room, revealed the resident sitting on the bedside eating lunch. Interview on October 10, 2012 at 1:35 p.m., in the resident's room, revealed "...both upper and lower dentures are loose and they have been loose for a long time...they have been loose since (resident) lost all this weight...have not seen a dentist but would like to see one..." Interview with the Social Services Worker #1, on October 10, 2012, at 2:05 p.m., in the conference room, revealed the dentist was in the facility on October 5, 2012, and did not see the resident. Further interview revealed Social Services was not aware of the ill-fitting dentures and the resident needed to be seen by the dentist. Continued interview revealed "...the nursing staff use the communication sheet to let us know if a resident has an issue and this is discussed in the morning stand-up meetings...we never got a communication sheet..."	F 282		

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F 282	Continued From page 17 Interview with the Secured Unit Manager on October 10, 2012, at 3:00 p.m., in the secured unit nurses station, revealed "...any issues are discussed in the morning stand-up meetings...the 24 hour shift reports are given to the manager and then taken to the stand-up meetings by the department head..." Further interview revealed "...we should have caught this and been on top of the issue..." Further interview confirmed dental services were not obtained for the resident. Interview with the Director of Nursing (DON) on October 10, 2012, at 2:00 p.m., in the conference room, confirmed dental services were not obtained for the resident.	F 282	**F315 No Catheter, Prevent UTI, Restore Bladder** Based on the resident's comprehensive assessment, the facility must ensure anyone who enters the facility without an indwelling is not catheterized unless the residents clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bowel and bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible **Resident Affected:** Resident #18 was assessed for a bowel and bladder program which was initiated on 10/16/12. **Residents potentially affected:** All residents who have not been assessed for a bowel and bladder program have the potential to be affected by the deficient practice. **Systemic measures:** The DON/designee will perform a 100% review of all residents who flagged for low risk incontinent episodes. A bowel and bladder assessment will be completed by the restorative nurse manager/designee. The restorative nurse manager will be educated by the DON/SDC on bowel and bladder assessment on admission and changes to bowel and bladder pattern. **Monitoring changes:** The DON/designee will review residents monthly that flag for low risk incontinence and ensure a completed bowel and bladder assessment was performed. Any bowel and bladder concerns identified will be addressed immediately and reported in monthly QA x 2 months.	11/16/12
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to implement an individualized bladder training program for one (#18) of three residents reviewed for urinary incontinence.	F 315		

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F 315	Continued From page 18 The findings included: Resident #18 was admitted to the facility on December 22, 2011, and readmitted on July 27, 2012, with diagnoses including Cerebral Vascular Accident, Dementia, and Diabetes Mellitus Type II. Medical record review of the quarterly Minimum Data Set (MDS) dated September 25, 2012, revealed the resident was occasionally incontinent of urine. Medical record review of a Bladder Management Assessment dated April 30, 2012, revealed "...Mental Status...confused...where does resident void...commode...continent..." Medical record review of a Nursing Admission Form dated July 27, 2012, revealed the resident was continent of bladder. Medical record review of a Diagnostic Interview Examination dated July 31, 2012, revealed "...urinary incont (incontinent)..." Observation on October 9, 2012, at 6:55 p.m., in the West Wing Hall, revealed the resident walking in the hall with the resident's brief exposed. Interview with Certified Nurse Aide (CNA) #1 on October 10, 2012, at 10:10 a.m., confirmed the resident wore a brief, incontinent of urine 2-3 times a days, continent of bowel, searched for the bathroom, and was not currently on a scheduled toileting program.	F 315		

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F 315	Continued From page 19 Interview with Licensed Practical Nurse (LPN) #2 on October 10, 2012, at 10:20 a.m., in the West Wing Nurse's Station, confirmed the resident was continent at times and searched for the bathroom. Interview with the Restorative Nurse on October 10, 2012, at 10:40 a.m., in the rehabilitation office, confirmed the MDS Coordinators completed quarterly assessments, would make referrals to restorative nursing when a decline was indicated, and the facility did not currently have any residents on a toileting program. Interview with the MDS Coordinator on October 10, 2012, at 11:00 a.m., in the conference room, confirmed no bowel and bladder assessment for September 2012, had been completed and no individualized bladder training program had been established for the resident.	F 315	**F323 Free of accident Hazards/Supervision And Devices** The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. **Resident affected:** The hemorrhoid pads were removed from room 206. **Residents potentially affected:** All residents have the potential to be affected by this cited practice. 100% of all rooms were searched for unattended medication. None were observed. **Systemic measures:** The department heads will perform walking rounds throughout the work week observing for unattended medications. Any medications observed in the rooms will be immediately removed and reported to the DON/designee. The resident will be assessed for self administration of medication per an interdisciplinary team. If resident is safe to administer medications a MD order must be obtained and a lockbox placed in their room for safety. **Monitoring changes:** The DON/designee will report any medications observed in rooms unattended to the administrator. Any medications observed during rounding unattended will be addressed in monthly QA x 2 months and upon occurrence thereafter.	11/16/12
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the resident environment remains free of accident hazards.	F 323		

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F 323	Continued From page 20 The findings included: Observation and interview with the Director of Operations, on October 9, 2012, at 7:58 a.m., in the bathroom of room 206, revealed a sixteen ounce jar, one-half full of hemorrhoid pads labeled, "if swallowed get medical help or contact a poison control center right away." Further interview at this time with the Director of Operations confirmed the facility had failed to maintain a resident environment free of accident hazards.	F 323	**F356 Posted Nurse Staffing Information** The facility must post the following information on a daily basis – facility name, the current date, the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift to include registered nurses, licensed practical nurses or vocational nurses, certified nurse aides and resident census. **Resident affected and potentially affected:** All residents have the potential to be affected by this cited practice related to staffing. The DON was educated on the staffing posted requirements per federal regulations. **Systemic Measures:** The DON/SDC/HR were educated on 10/8/12 related to the revised nursing staffing sheet that is posted and the importance of updating the sheet to reflect actual nursing staff and hours worked. The DON/SDC will educate charge nurses on daily staffing sheet and revising it when nursing staff level change. The human resource director/designee will review the daily staffing sheet daily throughout the work week x 1 month for accuracy of nursing staff, hours worked and census. The human resource director/designee will report any discrepancies to the DON/SDC related to the posted staffing sheet. **Monitoring changes:** The human resource director/designee will report discrepancies to the administrator weekly x 1 month. Any concerns with posted nursing sheet will be addressed in monthly QA.	11/16/12
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public	F 356		

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F 356	Continued From page 21 for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility documentation, and interview the facility failed to post the correct nurse staffing data. The findings included: Observation of the Nurse staffing on October 8, 2012, at 10:30 a.m., revealed seven Licensed Practical Nurses (LPN) and one Registered Nurse (RN) on duty. Observation and review of the posted nurse staffing data and interview with the Director of Nursing (DON), on October 9, 2012, at 11:30 a.m., in the front hallway, revealed the staff posted as eleven LPN's, and one RN. The actual staffing was seven LPN's and one RN. Interview with the DON confirmed the posted Nurse staffing was not accurate.	F 356	**F441 Infection Control, Prevent Spread, Linens** The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. **Residents affected:** Resident # 101, #49 nurse educated on 10/9/12 on the importance of wearing gloves while performing finger sticks, administering insulin and cleaning the glucometer machine. Resident #54 wheelchair was cleaned on 10/10/12 with disinfectant and CNA #1 and #2 were educated on handling of soiled linen by the DON. **Residents potentially affected:** All residents have the potential to be affected by staff not wearing gloves, soiled linen handling and not cleaning the blood glucose machines. The DON/designee began educating licensed nurses on 10/10/12 related to cleaning blood glucose machine, wearing gloves while performing an accucheck and administering insulin and direct care staff on hand washing and handling soiled linen. **Systemic measures:** The DON/ designee will educate licensed staff on cleaning glucose machines, wearing gloves while performing an accucheck and administering insulin and direct care staff on hand washing and handling soiled linen. The DON/designee will complete a competency on licensed staff regarding cleaning blood glucose machines, handwashing, accuchecks and administering insulin. The DON/designee will then perform a medication pass with 2 licensed nurses per month that receive insulin to ensure proper techniques and cleaning of equipment is performed. Any areas identified during the medication pass will be immediately corrected with the licensed nurse and education provided by the DON/designee. **Monitoring change:** The DON/designee will report concerns identified with infection control and medication pass in the clinical meeting and to the administrator throughout the week. Infection control issues identified will be addressed in QA monthly x 2 months and upon occurrence thereafter.	11/16/12
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		

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	445393	A. BUILDING _____ B. WING _____	10/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGE AT MONTEAGLE (THE)	26 SECOND STREET MONTEAGLE, TN 37356

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F 441	Continued From page 22 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to maintain infection control during an insulin injection for one resident (#101), failed to apply gloves prior to performing a finger stick and administering an insulin injection	F 441		

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F 441	Continued From page 23 for two residents (#49, #101), failed to follow infection control practice for handling of soiled linens for one resident (#54), and cleaning of the blood glucose monitor for one of five blood glucose monitors. The findings included: Observation on October 9, 2012, at 5:25 p.m., revealed Licensed Practical Nurse (LPN) #1 entered the room, placed the blood glucose monitor on the resident's bedside table, performed a finger stick and an insulin injection for resident #49 with ungloved hands. Further observation at this time revealed the LPN exited the room wiped the blood glucose monitor with a sani-wipe, immediately used the blood glucose monitor without allowing to dry. Observation on October 9, 2012, at 5:40 p.m., revealed Licensed Practical Nurse #1 performed a finger stick and an insulin injection for resident #101 with ungloved hands, dropped a lancet on the floor picked the lancet up from the floor and did not wash the hands. Review of facility policy, Handwashing, dated effective December 2010, revealed "...staff will wash their hands...to prevent the spread of infections or germs..." Review of facility policy, Cleaning of Equipment In Personal Contact, dated effective December 2010, revealed "...disinfect the exterior surface after each use...according to the guidelines provided by the manufacturer...1 minute...wipe dry or allow to air dry between cleaning and between each patient..."	F 441		

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F 441	Continued From page 24 Review of facility skill checklist, Cleaning of Equipment in Personal Contact, revealed "...follow manufacturer's guidelines for kill time...1 minute...wipe dry or allow to air dry in between use...place glucometer on clean barrier when cleaning..." Interview with LPN #1 on October 9, 2012, at 5:45 p.m., at the time of the observation, revealed gloves were to be worn when there is potential contact with blood or body fluids, and confirmed gloves were not worn when the finger stick and insulin injections were administered. Interview with the Director of Nursing (DON) on October 10, 2012, at 2:00 p.m., in the DON office, confirmed the facility failed to follow the facility policies for infection control, handwashing, and cleaning of equipment in personal contact. Resident #54 was admitted to the facility on March 12, 2012, with diagnoses including Cerebral Vascular Accident, Vascular Dementia, Hypertension, and Senile Dementia. Medical record review of the annual Minimum Data Set (MDS) dated April 4, 2012, revealed the resident was severely cognitively impaired and required extensive assistance with activities of daily living. Observation on October 10, 2012, at 2:30 p.m., in the resident's room, during incontinence care, revealed Certified Nursing Assistant (CNA) #2 and CNA #3 changing the resident's wet brief and clothes. Continued observation revealed CNA #2 took the soiled pants, placed them in a bag and	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 25 placed the dirty unsecured bag in the resident's wheelchair. Further observation revealed CNA #2 took the soiled brief, placed the brief in a bag and placed the dirty unsecured bag in the resident's wheelchair. Interview with CNA #2 on October 10, 2012 at 2:35 p.m., in the resident's room, confirmed the dirty contaminated unsecured bag with soiled linen and the soiled brief were placed in the resident's wheelchair during the incontinence care. Further interview confirmed the wheelchair is used during transfer to other departments and activities by the resident. Review of facility policy, Perineal Care, dated December 2010 revealed "...place bag of dirty laundry in barrel outside resident's room..." Interview with Licensed Practical Nurse (LPN) #2 (the unit charge nurse) on October 10, 2012, at 3:00 p.m., in the West Wing Nurses Station, confirmed the resident's wheelchair is used during transfer for the resident and contaminated articles should not be stored in the resident's wheelchair.	F 441	**F463 Resident Call system-Rooms/Toilet/Bath** 11/16/12 The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. **Resident affected:** The emergency call system in the resident's bathrooms on East Wing Hallway (rooms 114-130, 109-131), Central hallway (rooms 133-233, 132-232), West hallway (201-215, 202-216) were corrected the same day. A Call light system watch was initiated on 10/8/12 until the emergency call light system was properly functioning. **Residents potentially affected:** All residents have the potential to be affected by the emergency call light system in the bathroom not working properly. The maintenance director performed 100% audit of all emergency bathroom call lights. **Systemic measures:** The maintenance director/designee performed 100% audit on all emergency bathroom call lights on 10/8/12. The maintenance director/designee will check 50% of emergency bathroom call lights x 1 month beginning 10/23/12 then 25% of emergency bathroom call lights x 1 month beginning 11/23/12. The maintenance director/designee after 2 months will then check 10 rooms per month as preventative maintenance program. The maintenance director/designee will report to the administrator emergency bathroom call lights not functioning properly and fix them immediately. **Monitoring changes:** The maintenance director/designee will report to the administrator emergency bathroom call lights that aren't functioning properly. The administrator will report findings related to the emergency bathroom call lights to the monthly QA x 2 months and upon occurrence thereafter.	
F 463 SS=F	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility	F 463		

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F 463	Continued From page 26 failed to ensure the emergency call light systems, in the resident's bathrooms, were properly functioning for fifty-one of seventy-two resident rooms. The findings included: Observation on October 8, 2012, between 3:30 p.m. and 4:30 p.m., revealed the emergency call system in the resident's bathrooms were not functioning properly for the East Wing Hallway (rooms 114-130, 109-131), the Central Hallway (rooms 133-233, 132-232) and on the West Hallway (201-215, 202-216). Observation and interview with the Administrator on October 8, 2012, at 3:20 p.m., in the East Wing Hallway, confirmed the facility failed to ensure the emergency call lights, in the resident's bathrooms, were functioning properly for the East Wing Hallway (rooms 114-130, 109-131), the Central Hallway (rooms 133-233, 132-232) and on the West Hallway (201-215, 202-216).	F 463		